The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Board of Registration in Pharmacy
Bureau of Health Professions Licensure
250 Washington Street, Boston, MA 02108-4619
Tel: 617-973-0960
Fax: 617-973-0980
TTY : 617-973-0988
www.mass.gov/dph/boards/pharmacy

Change of Pharmacy Manager of Record

Use this application to change the pharmacist Manager of Record (MOR) of a Board of Registration in Pharmacy (Board) licensed pharmacy that is located in Massachusetts. This application, fee, and any required documents must be submitted within **10 business days of the outgoing MOR's departure date.** Review 247 CMR for complete information regarding applicable regulations. If additional information is necessary, please contact the Board office.

Retain copies of all documents for your records.
Do not submit Checklist, Inventory, or Inspection Template.

Checklist of items to be submitted:

☐ A fully and properly completed, signed, and notarized Change of Manager of Record Application (*see pages 2-4*).

☐ Required $525.00 fee: A check or money order must be payable to the *Commonwealth of Massachusetts*. Do not send cash, foreign currency, or electronic funds transfers. There will be a $23 handling charge for returned checks. **Fees are non-refundable and non-transferable**.

☐ Attestation of Inventory of Controlled Substances of all medications in Schedules II-V has been completed by the incoming and outgoing Managers of Record (*see pages 3*).
(**Do not submit the inventory, only the attestation.**)

☐ Complete the applicable Inspection Template within 30 days. (**Do not submit**.)

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Change of Manager of Record Application

TO BE COMPLETED BY BOARD

CHECK $_____DATE_____

CHECK NO. _____RECEIPT NO. _____APP NO. _____

Legal Name of Facility _____

All trade or business names ("D.B.A." names) _____

Tel. No. _____ E-mail _____

Street Address (physical address) _____

City/Town _____ State_____ Zip Code _____

Pharmacy License No. _____ RCP License No. (nuclear pharmacy only): _____

Has there been any change in the ownership or ownership structure of the pharmacy? ☐ Yes ☐ No

Date the Change of MOR took place: _____

Name of Outgoing MOR: _____ MA License No._____

Name of Interim Manager (if applicable): _____MA License No._____

Name of Proposed MOR: _____

MA License No. _____ NABP Profile No. _____

Has the proposed Manager of Record completed the continuing education requirements for the most recent two full calendar years? ☐ **Yes** ☐ **No**

Has the proposed MOR ever had:
1) any convictions related to the distribution of drugs (including samples);
2) any felony convictions;
3) any suspension(s) or revocation(s) or other sanction(s) by federal, state, or local governmental agency of any license or registration currently or previously held by the applicant or license for the manufacture, distribution, or dispensing of any drugs, including controlled substances, radiopharmaceuticals, and radioactive materials? ☐ **Yes** ☐ **No** *If yes, provide a full explanation on a separate page and attach a certified copy of each action and or court setting forth circumstances of such action(s).*

Has the proposed MOR ever been denied licensure by any federal or state agency including any state board of pharmacy? ☐ **Yes** ☐ **No** *If yes, provide a full explanation on a separate page.*

Attestation of Inventory of Controlled Substances

We attest that a complete inventory of controlled substances in Schedules II through V has been completed, signed by the outgoing MOR* and proposed MOR, and filed with the pharmacy's controlled substance records.

We attest that all Schedules II through V, and all required Schedule VI drugs have been reported to the PMP.

*In the event the outgoing Manager of Record is unavailable due to death, serious illness, or termination, a staff pharmacist may sign the inventory provided the Board is notified at the time the application is submitted as to the reason why.

OUTGOING MANAGER*	**PROPOSED MANAGER**
_____	_____
Print	**Print**
_____	_____
Signature	**Signature**
_____	_____
Date	**Date**

Affidavit (*must be signed and notarized)*

I certify under the penalties of perjury that I am the person authorized to sign this application and that all information provided is truthful, complete, and for lawful and honest purposes.

I have filed all state tax returns and paid all state taxes required under law pursuant to M.G.L. c. 62C, § 49A.

I have read and understand all applicable state and federal statutes and regulations regarding the operation of the facility and will notify the Board in writing of any changes in ownership or management within thirty (30) days of such change(s).

I certify that each employed person has the education, training, and experience, or any combination thereof, sufficient for that person to perform the assigned functions in such a manner as to provide assurance that the drug product quality, safety, and security will at all times be maintained as required by law or regulation.

_____

Name of proposed MOR

_____ _____

Signature Date

Sworn and subscribed before me this _____ day of _____

Notary Public Signature _____My commission expires _____

NOTARY SEAL